Filing at a Glance

Company:	Wesco Insurance Company
Product Name:	Single Case Association Filing - NCE
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	10/10/2012
SERFF Tr Num:	UNKP-128717823
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AH990017 NCE
Implementation Date Requested:	On Approval
Author(s):	Susan Coulter
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/26/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Wesco Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *Single Case Association Filing - NCE*
Project Name/Number: *NCE Single-Case LB Association Filing/AH990017 - NCE*

General Information

Project Name: NCE Single-Case LB Association Filing
Project Number: AH990017 - NCE
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Association
Filing Status Changed: 10/26/2012
State Status Changed: 10/26/2012
Created By: Susan Coulter
Corresponding Filing Tracking Number: UNKP-128614623

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:
Deemer Date:
Submitted By: Susan Coulter

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

On 8/7/12 the Department approved policy form AH990017 LB and related forms SERFF Tracking No. UNKP-128614623 for use in your state. The Company has recently issued a policy to the NCE association that have members in your state. This association is situsued in Delaware. Accordingly, the Company would like to issue the approved certificate of coverage (WIC-AH-AD-CERT NCE AR) to members of this association residing in your state. In accordance with your requirements we are submitting to you the articles of incorporation and by-laws for this association for your review and approval. The Company would also like approval of this association for use with other products as they are approved by the Department.

National Congress of Employers (NCE) – Situsued in Delaware and founded in 2006, this association was formed “to advocate on behalf of members, individually and collectively at the state and federal level and be a key business resource for small, independent business in America; to render public services as non-partisan, non-profit organization. To develop acquaintance and fellowship, undertake projects, and act upon matters of common interest and welfare to the members of the association; to instill, foster, encourage, and promote among members of the association the importance of adhering to the highest ethical standards of their respective professions; to establish facilities and provide forum for the interchange of ideas, opinions, technical know-how, networking and experiences among members of the association and other national and international organizations. Further, said corporation is organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 502(c)(3) of the Internal Revenue Code, or the corresponding section of any future tax code.”

We trust you will find the association acceptable. Please do not hesitate to contact us at wendy@coulter-and-associates.com or by phone at (609) 443-7540 should you have any questions.

Company and Contact

Filing Contact Information

Susan Coulter, susan@coulter-and-associates.com

State: *Arkansas* ***Filing Company:*** *Wesco Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *Single Case Association Filing - NCE*
Project Name/Number: *NCE Single-Case LB Association Filing/AH990017 - NCE*

379 Princeton-Hightstown Road,
Suite 15
Cranbury, NJ 08512

609-443-4140 [Phone]

Filing Company Information

Wesco Insurance Company
59 Maiden Ln, 6th Fl
New York, NY 10038
(212) 220-7120 ext. [Phone]

CoCode: 25011
Group Code: 2538
Group Name: AmTrust Financial Group
FEIN Number: 85-0165753

State of Domicile: Delaware
Company Type: Property & Casualty
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? Yes
Fee Explanation: $50/form - 1 form @ 50.00 = $50.00
Per Company: No

Company	Amount	Date Processed	Transaction #
Wesco Insurance Company	$50.00	10/10/2012	63648222

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/26/2012	10/26/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/11/2012	10/11/2012

Response Letters

Responded By	Created On	Date Submitted
Susan Coulter	10/24/2012	10/24/2012

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Disposition

Disposition Date: 10/26/2012
Implementation Date:
Status: Approved-Closed

HHS Status: Not Reported
State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Approved Policy for NCE	Approved-Closed	Yes
Supporting Document	NCE Governance Documents	Approved-Closed	Yes
Form (revised)	Limited Benefits Certificate	Approved-Closed	Yes
Form	Limited Benefits Certificate	Replaced	Yes

State: Arkansas **Filing Company:** Wesco Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: Single Case Association Filing - NCE
Project Name/Number: NCE Single-Case LB Association Filing/AH990017 - NCE

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/11/2012
Submitted Date	10/11/2012
Respond By Date	11/12/2012

Dear Susan Coulter,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Limited Benefits Certificate, WIC-AH-AD-CERT (0312) NCE AR (Form)
Comments:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Thank you for your cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/24/2012
Submitted Date	10/24/2012

Dear Rosalind Minor,

Introduction:

Please refer to the revised Certificate attached to this filing.

Response 1

Comments:

The revised Certificate does not set a time limit for furnishing proof of incapacity with respect to handicapped dependents.

Related Objection 1

Applies To:

- Limited Benefits Certificate, WIC-AH-AD-CERT (0312) NCE AR (Form)

Comments:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Thank you for your cooperation.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Limited Benefits Certificate	WIC-AH-AD-CERT (0312) NCE AR	CER	Initial		50.600	WIC-AH-AD-CERT (0312) NCE.pdf	Date Submitted: 10/24/2012 By: Susan Coulter
Previous Version								
1	*Limited Benefits Certificate*	*WIC-AH-AD-CERT (0312) NCE AR*	*CER*	*Initial*		*50.600*	*WIC-AH-AD-CERT(0312) NCE.pdf*	*Date Submitted: 10/10/2012 By: Susan Coulter*

No Rate/Rule Schedule items changed.

Conclusion:

I believe you will find this accpetable for approval. Should you have questions or need additional information, please contact me at 609.443.7540 or wendy@coulter-and-associates.com. Many thanks.

Sincerely,

Susan Coulter

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Form Schedule

Lead Form Number: WIC-AH-AD-CERT (0312) NCE AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/26/2012	Limited Benefits Certificate	WIC-AH-AD-CERT (0312) NCE AR	CER	Initial		50.600	WIC-AH-AD-CERT (0312) NCE.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

Policyholder: *National Congress of Employers, Inc.*

Policy Number: *NCE1234567*

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

Table of Contents
Definitions
Insured Person Period of Coverage
[Insured Dependent Period of Coverage]
Premiums
General Exclusions
Benefits
Claims

Group Limited Benefits Certificate of Coverage

[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS CERTIFICATE CAREFULLY.]
[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS CERTIFICATE CAREFULLY.]

Signed for Wesco Insurance Company

President

Secretary

GENERAL DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

[Active Work and Actively at Work – The eligible employee is performing all of the usual and customary duties of his or her or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the person to travel.]

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

[Confined and **Confinement** mean:
a) being admitted to a Hospital for receiving inpatient hospital services; and
b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.]

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.
3. Not one of the following:
   - A person who ordinarily resides in Your household
   - A member of Your immediate family
   - The Policyholder.

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and

[5. [You and Your Domestic Partner have filed a Domestic Partner affidavit with Us; and]

6. You and Your Domestic Partner are not legally married to anyone else.]

[Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4. provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.]

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident and independently of all other causes which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2. medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or **Insured Person** means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

[You must be Actively At Work on the date Your insurance becomes effective. (If the date that insurance was to go into effect is not a normally scheduled work day for You, You must have been Actively at Work on the last scheduled work day prior to the date insurance becomes effective under the Policy). If You are not so Actively at Work, Your insurance will be deferred until the date You are Actively at Work.]

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
   a) cease to be an Eligible Person;
   b) attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
   c) fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

a) are not eligible for the coverage requested, the change will not become effective;
b) are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:
1**. Spouse** means Your spouse [or Domestic Partner] unless:
a) You and Your spouse are legally separated or divorced [the domestic partnership is dissolved]; or
b) He or she has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means Your unmarried child, stepchild, legally adopted child, or foster child:
a) who is less than age [19] and primarily dependent on You for support and maintenance; or
b) who is at least age [19] but less than age [24] who:
1) regularly attends an institution of learning; and
2) is primarily dependent on You for support and maintenance.

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:
1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:
1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

[Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:
1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:
1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.]

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:
1. is not eligible for the coverage requested, it will not become effective; or
2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[Incapacitated Child: Coverage of a child who, on the date he or she reaches age [19] or [24], is:
1. covered under the Policy;
2. mentally or physically incapable of earning his or her own living; and
3. unmarried and primarily dependent on You for support and maintenance;

will not terminate solely due to age.

However, You must give Us written notice of the incapacity.

Coverage will continue as long as:
1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.]

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. [We will send you a bill for the premium due in advance of the due date.] See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony.

BENEFITS

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.]

[IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result, from no other causes, of Injuries sustained in a Covered Accident.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;
4. the date insurance under the Policy ends.]

[NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

[This benefit is not available to Covered Dependent Children.]

In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or **Totally Disabled** means, due to an Injury from a Covered Accident, a Covered Person:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and
2. if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.]

[EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the **Covered Injury**; and
4. the medical expenses are incurred within 52 weeks of the **Covered Injury**.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses
11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
12. X-ray expenses (including reading charges) but not for dental X-rays
13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
15. Ambulance expenses for transportation from the emergency site to the Hospital.
16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.

17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
12. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
13. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.

Exclusions:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
4. Travel outside of the United States of America.
5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
6. Treatment by an Immediate Family Member.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless Medically Necessary for the treatment of the Covered Injury.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [Experimental/Investigational treatments or procedures].
11. [A Medical Repatriation.]
12. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
13. Expenses which the Covered Person is not legally obligated to pay.
14. [Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.]
16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.]
17. [being legally intoxicated while operating a motor vehicle.
    a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.
18. [Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)].

In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

Experimental / Investigational means treatment, a device or prescription medication which is recommended by a Doctor, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.]

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1. on a monthly basis, after We receive the proof of loss, while the loss and liability continue; or
2. immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;
2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right, at our expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: We will recognize any assignment You make under the Policy, provided:

1. it is duly executed; and
2. a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.

SERFF Tracking #:	UNKP-128717823	**State Tracking #:**	**Company Tracking #:** AH990017 NCE

State:	Arkansas	**Filing Company:**	Wesco Insurance Company
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	Single Case Association Filing - NCE		
Project Name/Number:	NCE Single-Case LB Association Filing/AH990017 - NCE		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
AR LB Flesch Certification-Assoc Filing 20121008.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
Group App - Modified for AR (20120103 cc).pdf			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	10/26/2012
Bypass Reason:	Not applicable-not individual or Group/Individual Long Term Care and Medicare Supplement Filings.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/26/2012
Bypass Reason:	Not an Individual Health Product, Group/Individual Medicare Supplement or Long Term Care		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/26/2012
Bypass Reason:	Not PPACA related.		

		Item Status:	Status Date:
Satisfied - Item:	Approved Policy for NCE	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***	***Company Tracking #:*** *AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

AH990017 (0312) - CW - GROUP POLICY NCE.pdf
WIC-AH-AD-CERT (0312) NCE.pdf
WIC Rider EME (20120319 cc).pdf
WIC Rider ER (20120319 cc).pdf

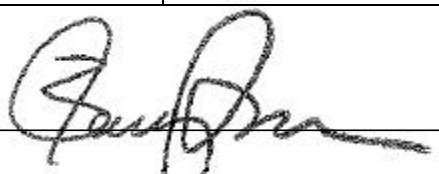
		Item Status:	**Status Date:**
Satisfied - Item:	NCE Governance Documents	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
NCE Constitution and By-Laws.pdf NCE Delaware Cert of Incorporation.pdf			

WESCO INSURANCE COMPANY

FLESCH CERTIFICATION

I, _Barry W. Moses_ an office of Wesco Insurance Company, certify that the forms listed below satisfy the NAIC Model Bill standards of life and health insurance policy language simplification legislation.

Form Number	Form Title	Flesch Score
WIC-AH-AD-CERT NCE AR	Group Certificate	50.6

Signature of Office: 

Title: _Vice President, Regulatory Compliance_

Date: _10/8/2012_

Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

Section I - Administrative Information

[Association]/Policyholder Name				
Policyholder Street Address (No P.O. Box)	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County
Phone ( )	Administrative Contact			
Fax ( )	Title			
Requested Effective (MM/[DD][01]/YYYY)	Email Address			
Describe the Nature of [Association][Business]				

[Will any of the selected coverage types be a takeover for an existing group coverage? ☐ Yes ☐ No

If yes, please specify coverage types_____ Effective date of prior coverage types_____

Prior Carrier Name_____ Termination date of prior coverage types_____]

Section II - Eligibility Requirements

Members in good standing of the association are eligible for insurance under the program. [Dependents of the Member are also eligible]

6. [Eligibility Waiting Period ☐ Yes ☐ No If "Yes", Number of days ☐ 0 ☐ 30 ☐ 60 ☐90 ☐ Other_____
   [Waiting Period applies to:
   - [☐ Persons who are Members in good standing prior to the effective date]
   - [☐ Actively at work employees working _____ hours per week.
   - [☐ Persons who become Members after the Policy Effective Date]

   [Do different classes have a different waiting period? ☐ Yes ☐ No
   If yes, please describe:]_____]

Section III – Benefits Selected:

Accidental Death and Dismemberment for all Covered Persons

Principal Sum Amount Options: [$5,000-$100,000]

Dependents Principal Sum is based on a percent of the Insured Person's Principal Sum:

Insured Person with Covered:*	Spouse/Domestic Partner	Each Child
Spouse [Domestic Partner], but no covered Child	50%	0%
Spouse [Domestic Partner]and Child(ren)	40%	10%
Child(ren), but no covered Spouse[Domestic Partner]	0%	15%

☐ **Accident Hospital Indemnity Benefit for all Covered Persons:**

Daily Hospital Confinement Benefit Amount: [$xxx-$xxx]
Maximum Benefit Period: [xxx] Days Per Confinement

☐ **Non-Occupational Weekly Disability Income Benefits for Insured Person Only**

Weekly Disability Benefit: [$XXX-XXX] reduced by the Reduction of Benefits Due to Other Sources of Income provision in the certificate
Benefit Waiting Period [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]]
Maximum Benefit Period of Disability [13, 26 weeks.]]

☐ **Accident Excess Medical Expense Benefit for all Covered Persons:**

Deductible: [$100-$200 per Certificate Year]
Coinsurance: [20%]
Maximum Benefit Amount per Covered Person per Covered Accident: [$10,000]
Benefit Limitations: Maximum Benefit Amount for Accident Dental: [$1,000]

☐ **Emergency Room Benefit:**

Amount Per Injury or Sickness: [$1,000-$5,000]
Annual Maximum Benefit Amount [$1,000-$5,000] per Covered Person

☐ **Emergency Medical Evacuation Benefit:**

Amount Per Evacuation: [$5,000-$50,000]
Minimum Number of Miles for Emergency Evacuation: [100-200]

Section V - General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. [Payment of the first premium by the policyholder after delivery of the Policy by us shall constitutes acceptance of the terms and conditions contained in the Policy so issued.]
2. [All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to us by the Policyholder.]
3. [This Application is subject to the approval of Wesco Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.]
4. [All benefits will be in accordance with the benefits proposed and agreed upon between Wesco Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.]

Policyholder responsibilities under this policy

The Policyholder agrees:

1. to maintain the records necessary to the administration of the Policy(s) and to make such records available to Wesco Insurance Company or its authorized administrator to ensure proper administration of the program;
2. to report additions, changes, terminations and other information necessary to the administration of the Policy(s) to the Wesco Insurance Company within 31 days after the Effective Date of such additions, changes and terminations;
3. [to pay all premiums in accordance with the terms of this Policy]; and
4. to notify all Insured Persons of any termination or rescission of coverage which affects them and refund the appropriate premium.]

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Wesco Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers We have provided are representations and not warranties.

BEFORE SIGNING THE APPLICATION, PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

(Arkansas) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(**Louisiana/Tennessee**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please Sign and Date

Dated at_____this_____day of_____,_____/___/____
City and State Date Month Year

By_____ _____ _____
Signature of Association Printed name of Association Job Title

[Association's Signature witnessed by (must be 18 or older):

_____ _____ _____
Signature of Witness Printed name of Witness Date]

[Signature of Agent/Producer:]

_____ _____ _____
Signature of Agent/Producer Printed name of Agent/Producer Date]

Section VI - Producer Information

Company/Brokerage Name
Company Address (if different than above) City, State Zip

Name of Agent Representing this Group		
Phone ( ) -	Fax ( ) -	Email Address
Producer Number		

Send Completed Application to:
[address]

Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

GROUP LIMITED BENEFITS INSURANCE POLICY

Policyholder Name: National Congress of Employers (NCE)

Policy Number: NCE1234567

Policyholder Address:

Place of Delivery:

Policy Effective Date: January 1, 2012

Policy Anniversary:

In return for the application, which is attached, and payment of premium as it becomes due, Wesco Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown above.

Signed for the Company

President

Secretary

THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.

THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS POLICY CAREFULLY.

TABLE OF CONTENTS

Schedules
Premium Provisions
Contract Provisions
Certificate of Insurance
Riders (if any)

SCHEDULE OF ELIGIBLE PERSONS

ELIGIBLE PERSONS:

ELIGIBLE MEMBER:

[All active members in good standing of the Policyholder who are:
a) under age [60-85];
b) full-time residents of the United States; and
c) not full-time members of any country's armed forces.]

[All full time employees working at least [17.5 - 40] hours per week. The employee must be Actively at Work in order for insurance to take effect.]

[ELIGIBLE DEPENDENTS: Eligible Person's Spouse [Domestic Partner] and Child(ren)
An Eligible Spouse [Domestic Partner] and/or Child may only be covered if the Eligible Person is covered under this Policy.

When an Eligible Person and his or her Spouse [Domestic Partner] are both Eligible Persons:
a) coverage may not be duplicated by enrolling as Dependents of each other; and
b) coverage for an Eligible Child may be requested only by the Eligible Person or the Eligible Dependent Spouse [Domestic Partner], but not both.

No Eligible Child can be covered unless the Eligible Person or Eligible Spouse [Domestic Partner] is covered under this Policy.]

POLICY AGE LIMIT: **[**None-100]

EVIDENCE OF INSURABILITY: None

Eligibility Waiting Period: [as determined by the Policyholder from the first day of eligibility]
[1-60 Days] [1-3 Months] from the first day of Active Work]
[1-60] [Days][1-3 Months]from the date a person first became a Member in good standing of the Policyholder]

Method of Premium Payment: [Remitted by Policyholder] [Remitted by Insured Person To Us]

SCHEDULE OF BENEFITS

BENEFITS AND AMOUNTS:

[Accidental Death and Dismemberment Benefit

Insured Person Principal Sum Amount
[$5,000-$100,000]

Principal Sum For each Insured Person's Eligible Dependents:

The Principal Sum applicable to each person covered under this policy as an Insured Person's Dependent is calculated by applying the percent, determined below, to the Insured Person's Principal Sum.

Insured Person with Covered:*	Spouse/Domestic Partner	Each Child
Spouse, but no covered Child	50%	0%
Spouse and Child(ren)	40%	10%
Child(ren), but no covered Spouse	0%	15%

*As determined on the date of accident

[Accidental Death and Dismemberment Reduction on and after Age 65: On the Premium Due Date on or next following a Covered Person's attainment of age 65, his or her amount of Principal Sum will reduce by 50%.]

[Accidental Death Reduction on and after Age 70: On the Premium Due Date on or next following the Covered Person's attainment of :

a) age 70, his or her amount of Principal Sum will reduce by 50%; and
b) age 75, his or her amount of Principal Sum will reduce further by 50%.]

[Aggregate Limit of Liability: [$1,000,000 - $10,000,000]
Aggregate Limit of Liability means the total Accidental Death and Dismemberment benefit amount that We will pay for all Covered Persons involved in a single Covered Accident who suffer a Cover Loss. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each Covered Person, We will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.]

[Accident Hospital Indemnity Benefit for all Covered Persons:
Daily Hospital Confinement Benefit Amount: [$30-$500]
MaximumBenefit Period: [30-365] Days Per Confinement
]

[Non-Occupational Weekly Disability Income Benefits for Insured Person Only
Weekly Disability Benefit: [$100 - $2,000] reduced by the Recution of Benefits Due to Other Sources of Income provision in the certificate
Benefit Waiting Period [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]]
Maximum Benefit Period of Disability [13, 26 weeks.]]
]

[Accident Excess Medical Expense Benefit for all Covered Persons:
Deductible: [$100-$200]
Coinsurance: [10-30%]
Maximum Benefit Amount per Covered Person per Covered Accident: [$1,000 - $50,000]
Benefit Limitations: Maximum Benefit Amount for Accident Dental: [$750-$5,000]
]

SCHEDULE OF PREMIUMS

INDIVIDUAL PREMIUMS: The premium is on file with the Policyholder.

ENROLLMENT

INITIAL ENROLLMENT: For Members who are eligible on the Policy Effective Date, Members should enroll within [0-60 days] of the Policy Effective Date. Members who are eligible after the Policy Effective Date should enroll themselves and their Eligible Dependents within [0-60 days] of their Eligibility Waiting Period. Members who do not enroll within the Eligibility Waiting Period must wait until the next Open Enrollment Period.

OPEN ENROLLMENT: Members may enroll themselves and their Eligible Dependents during an Open Enrollment Period. Other changes may also be restricted to Open Enrollment Periods.

Open Enrollment Period means the period of time specified by the Policyholder during which an Eligible Member may enroll for insurance if he or she did not enroll during the Eligibiilty Waiting Period. It usually occurs once each Policy Year but may, at the Policyholder's discretion, occur more frequently, if approved by Us.

PREMIUM PROVISION

POLICY PREMIUM: The premium for this policy is on file with the Policyholder.

PREMIUM DUE DATES: The Policy Premium is payable on the Policy Effective Date and each year thereafter. Each Policy Premium is due in advance of the date it becomes payable.

This policy terminates on the last day of the period for which premium is paid unless continued in force during a grace period.

PAYMENT: The Policy Premiums are to be paid to us by the Policyholder. However, they may be paid to us by any other person according to a mutual agreement among the other person, the Policyholder and us.

GRACE PERIOD: A grace period of 31 days is allowed for payment of each premium due after the first unless this policy is cancelled on or before the due date. This policy will continue in force during the grace period. The Policyholder is liable to us for the payment of premium accruing for the period this policy continues in force.

CHANGE OF PREMIUMS: We have the right on any date after the first anniversary, to change the rate at which further premiums will be calculated. We will give

the Policyholder notice of any change at least [30, 45, 60] days before the Due Date on which it is to become effective.

CONTRACT PROVISIONS

ENTIRE CONTRACT: The entire contract between the Policyholder and Us consists of this policy, the certificate of insurance, any individual enrollment forms, the group application, and any papers made a part of this policy at issue.

CHANGES: No agent has authority to change or waive any part of this policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made a part of this policy.

TIME PERIODS: All periods begin and end at 12:01 A.M., Standard Time at the place where this policy is delivered.

CERTIFICATES: We will give certificates to:

a) the Policyholder; or
b) any other person according to a mutual agreement among the other person, the Policyholder, and us;

for delivery to Insured Persons.

The certificates will state the features of this policy which are important to Insured Persons.

NEW ENTRANTS: New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

DATA FURNISHED BY POLICYHOLDER: The Policyholder will, upon Our request, give us:

a) the names of all persons initially eligible;
b) the names of all additional persons who become eligible;
c) the names of all persons whose benefits are to be changed;
d) the names of all persons whose insurance is canceled; and
e) any data necessary to calculate premiums.

The Policyholder's failure to report a person's termination of insurance does not continue the coverage beyond the date of termination.

The Policyholder, with Our approval, may keep the important insurance records on all Covered Persons. The Policyholder must give Us information, when and in the manner We ask, to administer the insurance provided by this policy.

The Policyholder's insurance records will be open for Our inspection at any reasonable time.

CANCELLATION: This policy may be canceled at any time by written notice mailed or delivered by Us to the

Policyholder or by the Policyholder to Us. If We cancel, We will mail or deliver the notice to the Policyholder at its last address shown in Our records.

If We cancel, it becomes effective on the later of:

a) the date stated in the notice; or
b) the 31st day after We mail or deliver the notice.

If the Policyholder cancels, it becomes effective on the later of:

a) the date We receive the notice; or
b) the date stated in the notice.

In either event:

a) We will promptly return any unearned premium paid; or
b) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis.

Cancellation will not affect any claim for loss due to an accident which occurs before the effective date of the cancellation.

NOT IN LIEU OF WORKERS' COMPENSATION: This policy does not satisfy any requirement for workers' compensation insurance.

INCORPORATION PROVISION: The Certificate(s) of Insurance and Riders listed below are attached to, incorporated in and made a part of this Policy.

Form	Applicable To	Effective Date of Incorporation
Certificate of Insurance Form	All Eligible Persons	January 1, 2012
Rider Form WIC RIDER EME	All Eligible Persons	January 1, 2012
Rider Form WIC RIDER ER	All Eligible Persons	January 1, 2012

Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

Policyholder: *National Congress of Employers, Inc.*

Policy Number: *NCE1234567*

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

Table of Contents
Definitions
Insured Person Period of Coverage
[Insured Dependent Period of Coverage]
Premiums
General Exclusions
Benefits
Claims

Group Limited Benefits Certificate of Coverage

[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS CERTIFICATE CAREFULLY.]
[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS CERTIFICATE CAREFULLY.]

Signed for Wesco Insurance Company

President

Secretary

GENERAL DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

[Active Work and Actively at Work – The eligible employee is performing all of the usual and customary duties of his or her or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the person to travel.]

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

[Confined and **Confinement** mean:
a) being admitted to a Hospital for receiving inpatient hospital services; and
b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.]

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.
3. Not one of the following:
   - A person who ordinarily resides in Your household
   - A member of Your immediate family
   - The Policyholder.

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and

[5. [You and Your Domestic Partner have filed a Domestic Partner affidavit with Us; and]

6. You and Your Domestic Partner are not legally married to anyone else.]

[Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4. provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.]

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident and independently of all other causes which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2. medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or **Insured Person** means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

[You must be Actively At Work on the date Your insurance becomes effective. (If the date that insurance was to go into effect is not a normally scheduled work day for You, You must have been Actively at Work on the last scheduled work day prior to the date insurance becomes effective under the Policy). If You are not so Actively at Work, Your insurance will be deferred until the date You are Actively at Work.]

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
   a) cease to be an Eligible Person;
   b) attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
   c) fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

a) are not eligible for the coverage requested, the change will not become effective;
b) are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:
1**. Spouse** means Your spouse [or Domestic Partner] unless:
a) You and Your spouse are legally separated or divorced [the domestic partnership is dissolved]; or
b) He or she has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means Your unmarried child, stepchild, legally adopted child, or foster child:
a) who is less than age [19] and primarily dependent on You for support and maintenance; or
b) who is at least age [19] but less than age [24] who:
1) regularly attends an institution of learning; and
2) is primarily dependent on You for support and maintenance.

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:
1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:
1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

[Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:
1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:
1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.]

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:
1. is not eligible for the coverage requested, it will not become effective; or
2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[Incapacitated Child: Coverage of a child who, on the date he or she reaches age [19] or [24], is:
1. covered under the Policy;
2. mentally or physically incapable of earning his or her own living; and
3. unmarried and primarily dependent on You for support and maintenance;

will not terminate solely due to age.

However, You must give Us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:
1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.]

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. [We will send you a bill for the premium due in advance of the due date.] See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony.

BENEFITS

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.]

[IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result, from no other causes, of Injuries sustained in a Covered Accident.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;
4. the date insurance under the Policy ends.]

[NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

[This benefit is not available to Covered Dependent Children.]

In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or **Totally Disabled** means, due to an Injury from a Covered Accident, a Covered Person:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and
2. if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.]

[EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the **Covered Injury**; and
4. the medical expenses are incurred within 52 weeks of the **Covered Injury**.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses
11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
12. X-ray expenses (including reading charges) but not for dental X-rays
13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
15. Ambulance expenses for transportation from the emergency site to the Hospital.
16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.

17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
12. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
13. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.

Exclusions:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
4. Travel outside of the United States of America.
5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
6. Treatment by an Immediate Family Member.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless Medically Necessary for the treatment of the Covered Injury.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [Experimental/Investigational treatments or procedures].
11. [A Medical Repatriation.]
12. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
13. Expenses which the Covered Person is not legally obligated to pay.
14. [Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.]
16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.]
17. [being legally intoxicated while operating a motor vehicle.
    a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.
18. [Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)].

In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

Experimental / Investigational means treatment, a device or prescription medication which is recommended by a Doctor, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.]

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1. on a monthly basis, after We receive the proof of loss, while the loss and liability continue; or
2. immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;
2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right, at our expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: We will recognize any assignment You make under the Policy, provided:

1. it is duly executed; and
2. a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.

Wesco Insurance Company
Cleveland, OH 44131

EMERGENCY MEDICAL EVACUATION BENEFIT RIDER

THIS RIDER PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES LIMITED SICKNESS COVERAGE. IT IS, THEREFORE, IMPORTANT TO READ THIS RIDER CAREFULLY.

The [Policy] [Certificate] to which this Benefit Rider is attached is amended to include the following benefit:

This Ride is subject to all of the terms and condition of the Policy which are not in conflict with the terms of this Rider.

EMERGENCY MEDICAL EVACUATION EXPENSE COVERAGE

Subject to satisfaction of the Deductible Amount, We will pay the Benefit Amount shown in the Emergency Medical Evacuation Benefit Schedule if a Covered Person requires Emergency Medical Evacuation. Benefits payable are subject to the Benefit Amount shown in the Schedule.

Emergency Medical Evacuation Benefit Schedule	
Benefit Amount:	[$5,000 - $50,000]
Deductible Amount:	[$100 - $250 per evacuation]
Minimum Number of Miles	[50-200]

A Doctor, in coordination with the assistance company [*insert name of Assistance Company and contact information*], must order the Emergency Medical Evacuation and must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Emergency Medical Evacuation to the closest adequate Hospital for the purpose of stabilizing the Covered Person's condition. It must be determined that such Emergency Medical Evacuation is required due to the inadequacy of local facilities and that the closest adequate Hospital is at least the Minimum Number of Miles shown in the Schedule from where the Covered Person resides.

Exclusions and Limitations: In addition to any appropriate Exclusions and Limitations shown in the Policy, We will not pay for any Emergency Medical Evacuation that is:
1) against the advice of a Doctor; or
2) for the purpose of obtaining medical care for a condition that is not the result of an Injury or Emergency Sickness.

Definitions: As they relate to this benefit.

Common Carrier means any regularly scheduled land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire.

Covered Emergency Evacuation Expenses are the usual and customary expenses for necessary Transportation, related medical services and medical supplies incurred in connection with the Emergency Medical Evacuation of an Covered Person. All Transportation arrangements made for evacuating the Covered Person must be by the most direct and economical route possible. Expenses for Transportation must be:
1) ordered by the attending Doctor who must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Emergency Medical Evacuation and adequate medical treatment is not locally available;
2) required by the standard regulations of the conveyance transporting the Covered Person; and
3) authorized in advance by [*add appropriate contact information – Insurer or name authorized representative*]. In the event the Covered Person's Injury or Emergency Sickness prevents prior authorization of the Emergency Medical Evacuation, [*add appropriate contact information*] must be notified as soon as reasonably possible.

Emergency Medical Evacuation means the Covered Person's medical condition warrants immediate transportation from the place where the Covered Person is Injured or Sick to the nearest Hospital where appropriate medical treatment can be obtained.

Emergency Sickness means an illness or disease, diagnosed by a legally licensed Doctor, which meets all of the following criteria:

1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Covered Person's condition or place his or her life in jeopardy;
2) the severe or acute symptom occurs suddenly and unexpectedly; and
3) the severe or acute symptom occurs while coverage is in force.

Transportation means any land, sea or air conveyance required to transport the Covered Person during an Emergency Medical Evacuation. Transportation includes, but is not limited to, Common Carrier, air ambulances, land ambulances and private motor vehicles.

Usual and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the city in which the charge is incurred.

Special Limitation: In the event [*add appropriate contact information*] could not be contacted to arrange for emergency Transportation, benefits are limited to the amount We would have paid had We or Our authorized representation had been contacted.**]**

In Witness Whereof We Have caused this Rider to be signed by our President and Secretary.

Secretary

President

Wesco Insurance Company

Cleveland, OH 44131

EMERGENCY ROOM BENEFIT RIDER

THIS RIDER PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES LIMITED SICKNESS COVERAGE. IT IS, THEREFORE, IMPORTANT TO READ THIS RIDER CAREFULLY.

The [Policy] [Certificate] to which this Benefit Rider is attached is amended to include the following benefit:

This Rider is subject to all of the terms and condition of the Policy which are not in conflict with the terms of this Rider.

EMERGENCY ROOM COVERAGE

We will pay the Benefit Amount shown in the Emergency Room Benefit Schedule if a Covered Person requires Medically Necessary treatment by a Doctor in a Hospital emergency room for a Medical Emergency due to Injury or Sickness. This benefit will be paid in addition to any other benefits that may be payable under the Policy.

Emergency Room Benefit Schedule	
Benefit Amount:	[$100-$1,000] per Visit
Maximum Number of Visits:	[1-5] Visits per Covered Person per Calendar Year

Exclusions and Limitations to**:** In addition the appropriate Exclusions shown in the Certificate of Coverage, We will not pay for any loss as a result of:

1) All types of hernia, however caused,
2) Injury or Sickness arising out of or in the course of employment for wage or profit, unless the Covered Person is ineligible for or legally exempt from Workers' Compensation coverage;
3) any loss to which a contributing cause was the Covered Person's being engaged in any illegal occupation or activity;
4) Injury or Sickness to which a contributing cause was the Insured Person being under the influence of or resulting from the use of intoxicants, including alcohol; or
5) related to pregnancy or childbirth; except that Complications of Pregnancy will be covered as any other Sickness;
6) any loss to which a contributing cause was the Covered Person's participation as a professional in athletics.

Pre-Existing Conditions Limitation: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following a Covered Person's Effective Date of Coverage under the Group Policy. This limitation will not apply to any loss due to pregnancy.

Definitions: As they relate to this benefit:

Medical Emergency means the sudden onset of a medical condition for which the Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one that manifests itself by acute symptoms that are sufficiently severe that, without immediate medical attention, could reasonably be expected to result in:

1. placing the Insured Person's health in serious jeopardy;
2. serious impairment of bodily functions; or
3. serious dysfunction of any bodily organ or part.

Medically Necessary means treatment that is prescribed by Your Physician to diagnose or treat an Injury or Sickness, that are known to be safe and effective by the majority of licensed Physicians who diagnose or treat that Injury or Sickness.

Sickness means a sickness, illness or disease which occurs after the effective date of coverage under this certificate and while this certificate is in force. Pregnancy will be considered the same as Sickness under the Policy.

In Witness Whereof We Have caused this Rider to be signed by our President and Secretary.

Secretary

President

CONSTITUTION AND BY-LAWS OF
OF
NATIONAL CONGRESS OF EMPLOYERS, INC.

ARTICLE I
NAME & OFFICE

Section 1 - Name

The name of the association shall be the National Congress of Employers, Inc., hereinafter referred to as "NCE" or the "Association". NCE is a corporation incorporated in the State of Delaware with its principal place of business in the District of Columbia. NCE's By-Laws shall be governed and interpreted by the laws of the State of New York.

Section 2 - Office

The principal offices of the Association shall be located at 1101 Pennsylvania Avenue, Washington, D.C. and additional Chapter offices in New York and any other location the Board deems appropriate.

Section 3 - Registered Agent

The registered agent of the Association is National Registered Agent, Inc. located at 160 Greentree Drive, Suite 101, County of Kent, Dover, Delaware, 19904.

ARTICLE II
SEAL

Section 1 - Seal

The Association shall have a common seal consisting of a design to be determined by vote of the Board of Directors. The seal shall contain the name of the organization in a semi-circular fashion and the year of formal organization, 2006, surrounding or overwritten on an acceptable symbol embodying the purpose of the organization.

ARTICLE III
PURPOSE

Section 1 - Purpose

The purpose of NCE is to establish facilities and provide a forum for the exchange of ideas, opinions, technical know how and experiences among NCE's members as well as other national and international organizations and to engage in any other lawful purpose.

ARTICLE IV
MEMBERSHIP

Section 1 - Qualifications

NCE is a private, fraternal organization which neither seeks nor accepts public or corporate funding in any form. Membership is reserved for those individuals that embody the purposes and ideals of the NCE as defined by the Board of Directors. NCE, through its Board of Directors, shall not deny membership to any protected class of people set forth in Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1866, the Civil Rights Act of 1991, including, but not limited to, on the basis of race, religion, national origin, sexual orientation and/or gender or for any protected class of people as identified by the New York State Human Rights Laws or the Human Rights Laws of any other jurisdiction which NCE does business in.

Section 2 - Classification of Members

Membership into this organization shall be classified as follows:

1. Charter Members - These shall include the names of founding members: Hon. George F. Sabatella, Hon. Robert DiCarlo, Christopher G. Sabatella, Matthew D. Saronson, Andrea Ceretti and Michael DiFilippo.

2. Active Members - These shall include individuals operating sole proprietorships and other like situated individuals duly enrolled and in good standing, having been approved for full membership by the Board of Directors or their duly authorized delegated Membership Committee.

3. Associate Members - These shall include individuals that are members of the Association, but do not enjoy voting rights, cannot hold the position of committee chairman, nor have access to the other emollients of Full Membership.

4. Supporting Members - These shall include individuals who are conferred membership as such by the Board of Directors with rights as specified thereupon.

Section 3 - Rights and Privileges

1. Charter Member - They shall be entitled to all the privileges and services offered by the association and shall serve as permanent members of the Board of Directors.

2. Active Member - They shall be entitled to all the privileges and services offered by the Association. Each member may vote and be voted upon for office in the Association.

3. Associate Member - They shall include individuals that are members of the

Association, but do not enjoy voting rights, cannot head committee chairmanships nor have access to the other emollients of full membership.

4. Other Privileges - Other membership privileges include participation in various activities, programs and publications of the Association as may be designated from time to by the Board of Directors.

Section 4 - Fees and Dues

1. The Board of Directors may at any meeting of the Board adjust the membership dues applicable to the classes of members enumerated in these By-Laws without amending the By-Laws. Provided, however, that any dues increase which exceeds the cumulative increase of the Composite Consumer Price Index since the last dues increase must be confirmed by a supermajority of the Board of Directors. A supermajority shall be defined as 75% or more of the then sitting Board of Directors. Dues shall be payable in advance of the month due.

2. The Board of Directors shall determine the charges for all other fees associated with the meetings, publications, or other services provided by the Association.

3. Monthly membership dues will include fees for general membership meetings and publications.

Section 5 - Admission and Effectiveness of Membership

1. Applications for membership shall be made in writing. Applications shall be processed by the membership committee. The applicant will be advised of action taken on their application.

2. Effectiveness of membership shall start from the payment of entrance fees and membership dues of the applicant and after submission of other requirements that may be imposed by the membership committee and/or Board of Directors.

3. Fees shall be paid within thirty (30) days after official approval of application for membership.

Section 6 - Members in Good Standing

In order to be a member in good standing, a member shall have paid all dues and assessments within thirty (30) days after the same shall have become due and payable.

Section 7 - Liability of Members

Members who have not fully paid their annual dues and other obligations to the

Association shall be liable for any indebtedness of the Association to the extent of their unpaid accounts.

Section 8 - Termination of Membership

Any member may be separated from membership for any of the following causes:

1. Any member who shall have defaulted in the payment of dues and assessments for two (2) successive months shall be automatically suspended after dues notices had been given and will forfeit all rights and privileges in the Association; provided, however, that any member so suspended may be reinstated to full standing upon payment of all dues in arrears and upon the approval of the majority of the Board of Directors.

2. Any other cause or causes detrimental to the Association upon which, after due notice, investigation and hearing, the Board of Directors votes in favor of termination.

ARTICLE V
MEETINGS

Section 1 - Annual Meetings

The annual general membership meeting, for the purpose of election of the Board of Directors, shall be held on the third Friday of December of each year at the principal office of the Association or at any place in the State of New York or District of Columbia to be decided on by the Board of Directors.

The order of business shall be as follows:

- Reading of the Minutes and of the last Annual General Membership Meeting and approval thereof;
- Report of the Treasurer;
- Report of the President;
- General Annual Elections of the Board of Directors;
- Unfinished business;
- New and other business;
- Report of the election committee and announcement of the results of the election.

Section 2 - Special Meeting

Special meetings of the Association may be called anytime by the Executive Director or by a majority of the Board of Directors whenever either shall deem it necessary.

Section 3 - Notice of Meetings

The notice of the annual meetings or special meetings must be provided to all members in writing at least one (1) week before the meeting, either by letter, fax or electronic mail.

Section 4 - Quorum

A simple majority (50% + 1) of the Active members in good standing, including proxies, shall constitute a quorum for the election of the Directors or for the transaction of any other business except in those cases where the By-Laws require the affirmative vote of a greater proportion.

The final list of candidates, arranged alphabetically, will be circulated to all voting members not later than fifteen (15) days before the election. The list shall not indicate the number of nominations received by each candidate.

In the event that the number of candidates equal or would be less than the number of elective positions, the nomination shall be declared re-opened by the Election Committee on the floor during election day.

Section 5 - Voting of Members

Founding and Active Members in good standing (Voting Members) may vote at all meetings. Each Voting Member is entitled to one vote that may be cast either in person or with approval of the Board of Directors via telephonic participation. In voting for members of the Board of Directors, each Voting Member shall vote a maximum of nine (9) different candidates. If any voting member cannot attend the election, he may submit a written proxy to the committee on election before the election, which shall be used for quorum purposes only.

Section 6 - Certification

Prior to the elections, the Committee on Elections shall certify that the candidates are qualified and have been nominated in accordance with the Constitution and By-Laws of the NCE.

Section 7 - Election of Directors

The election of Directors shall be by secret ballot. Action on all other matters shall be by "aye" or "nay" vote or by other means as the majority present may decide.

Section 8 - Manner in Deciding Tie

Should there be a tie in the election for a Director, the same shall be decided by a flip of a coin by the candidates with an equal number of votes.

Section 9 - Campaign

Any candidate for election may campaign for his candidacy by sending personalized letters bearing only the name and address of the sender and not the official letterhead of the Association. Any other form of campaigning is disallowed and considered a violation of election rules. However, on the election floor, candidates may distribute personal business cards.

Section 10 - Violation of Rules

Any willful violation of election rules by any member of the Association shall disqualify them from running for office and/or voting during the election and will subject them to disciplinary action.

ARTICLE VII
BOARD OF DIRECTORS

Section 1 - Number and Term of Office

The management of the affairs of the Association shall be vested in the Board of Directors consisting of no fewer than four (4) and no greater than nine (9) members who shall be elected bi-annually by the voting members of the Association.

Section 2 - Quorum

The Directors shall act only as a Board. No individual Director shall have the power to act on behalf of the Board. An attendance of a quorum of Directors is necessary at all meetings for the transaction of any business and every decision of majority of those present shall be valid as an Association act. A Quorum shall consist of a simply majority of Directors (50% + 1).

Section 3 - Regular Meetings

The Board of Directors shall hold regular meetings every second Wednesday of the month at the office of the Association or at any date and place to be designated by the Board.

Section 4 - Special Meetings

Special meetings of the Board of Directors may be called by the Executive Director or at the written request of the majority of the Directors. Notice of special meetings shall be given at least one (1) week before the date of the meeting. Notice of such meetings shall be deemed waived if all members of the Board are present.

Section 5 - Powers

The Board of Directors shall exercise the following powers and such other powers as may be provided for by the laws of the State of New York:

1. To promulgate such rules and regulations not inconsistent with these By-Laws;

2. to manage the affairs of the Association within the context of the By-Laws and Articles of Incorporation;

3. To purchase or acquire or sell or dispose of assets for the Association on such terms and conditions as it shall be deemed proper;

4. To employ and fix the compensation of the administrative officer, employees and other officers of the Association;

5. To act on all matters as may be designated by the Association as a whole;

6. To alter, merge or subdivide the Association as the Board sees fit and to best serve the interests of the membership;

7. To perform any and all tasks necessary to further the interests of the Association, limited only by these By-Laws and the laws of the State of New York;

8. To enter into partnership agreements or strategic alliances with like intended Associations or groups;

9. Approves an annual budget and financial audit;

10. Approves the time and place for the annual meetings of the members and the Board of Directors and all business meetings of the Board.

11. Hire and dismiss staff as it deems necessary;

12. Approves all committees and organizational appointments;

13. Fills vacancies on the Board of Directors;

14. Serves as the primary strategic planning unit for the Association;

15. Establishes organizational policies and develops strategies and allocates resources to implement same; and

16. Allow telephonic meetings with a speaker system in place that allows all callers on the call to be heard and to be able to speak to all others present on the telephone call.

Section 6 - Resignation

Any Director or officer may resign his office in writing. Such resignation should take effect upon approval and clearance by the Board.

Section 7 - Vacancy

In the event of any vacancy in the Board of Directors by reason of resignation, termination, death, inability to discharge responsibilities, or for any other reason acceptable to the Board, said vacancy shall, with the approval of the remaining Board of Directors be filled by the surviving spouse of the Director, for the remainder of that Director's term of office. Subsequent vacancies shall likewise be filled in the same manner.

If the vacancy is in the ranks of principal officers of the Board, it shall be filled by election from among the members of the Board during the next regular or special meeting held for the propose.

ARTICLE VIII
OFFICERS

Section 1 - Principal Officers

Within the next fifteen (15) days after the election, as provided for in Article V, Section 1, the members of the Board of Directors shall elect from among themselves the Executive Director, President, Secretary and Treasurer.

Section 2 - Subordinate Officers

The Board, in its discretion, may create those new, subordinate offices they deem necessary. The subordinate officers shall be members of the Association, shall be appointed by the Board of Directors. The subordinate officers may be employed by the Board of Directors who shall determine the compensation of all subordinate officers.

Section 3 - Compensation of Officers

The President, Executive Director, Secretary, Treasurer and members of the Board of Directors shall receive no compensation. Salaries and compensation of other officers shall be fixed by the Board of Directors, provided that no member of the Association shall be appointed or elected to any position carrying with it compensation.

ARTICLE IX
DUTIES OF OFFICERS

Section 1 - Powers and Duties of the Executive Director

The Executive Director shall be the Chief Executive Officer of the Association and, as such, shall exercise all the powers and discharge all such duties regularly or continually inherent in his office under the law, and such others as may be required by resolutions of the Board of Directors and of the Association.

Section 2 - Powers and Duties of the President

The President shall act as Deputy Executive officer and shall exercise and discharge all the powers and the duties of the President in case of the disability or absence of a Deputy Executive Officer. The President shall have direction of the following standing committees:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee
4. Education Committee
5. Legal Committee
6. Charitable Works Committee
7. Other committees and functions as may be assigned to him.

Each committee shall be headed by a Chairperson.

Section 3 - Powers and Duties of the Secretary

The Secretary, who must be a member of the NCE, shall be the custodian of all corporate records and other minutes of all meetings of the Association and of the Board of Directors. He shall issue notices of meetings and prepare the Order of Business thereof. He shall keep in safe custody the seal of the Association and when authorized by the Board of Directors, shall affix such seal to any instrument requiring the same. The seal so affixed shall be attested by him. He shall perform such other duties as may be delegated to him by the Executive Director or the Board of Directors or as may be required of him.

Section 4 - Powers and Duties of Treasurer

The Treasurer shall be the finance officer of the Association and as such shall be the custodian of all funds and properties of the Association. He shall have charge of all the books of accounts of the Association. He shall be responsible for the collection of all the fees and dues from members. He shall make an annual financial report to the Association and such other reports as the Board of Directors may require.

ARTICLE X
COMMITTEES

Section 1 - Standing Committees

There shall be three major standing committees governed by a fourth, governed by the Executive Committee, namely:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee

All standing committees shall submit their master program for the fiscal year to the Board not later than the second regular Board meeting.

Section 2 - Executive Committee

It shall be composed of the Executive Director, the President, the Secretary, the Treasurer and the Chairman of each of the three standing committees.

The committee shall be responsible for the preparation of the annual budget for submission to the Board of Directors not later than the second regular meeting of the Board. It shall also formulate policies and procedures in furtherance of the objectives of the Association for submission to the Board, and direct the governance and running of the standing committees. It shall also perform such other duties as may be delegated by the Board of Directors.

ARTICLE XI
GENERAL PROVISIONS

Section 1 - Fiscal Year

The fiscal year shall begin on January 1 and end on December 31 of the same year.

Section 2 - Budget

The Board of Directors shall approve the annual budget of the Association within fifteen (15) days after receipt of the recommended budget from the Executive Committee. The approved budget shall be the appropriate measure of the Association. No expenditures in excess of the budget shall be authorized without the prior approval of the Board of Directors.

Section 3 - Signatories

All disbursements of funds of the Association shall be made by checks. Checks shall be signed by the Executive Director and countersigned by the President. The Board of Directors may authorize any officer or officers to sign in place of the duly authorized signatories.

ARTICLE XII
AMENDMENTS

Section 1 - Amendments

A two-thirds majority of the members of the Board of Directors may amend or repeal these By-Laws or adopt new By-Laws.

ARTICLE XIII
TRANSITORY PROVISIONS

Section 1 - Regular Members

All Charter, Active Associate and supporting members of the Association in good standing as of the approval of these amended By-Laws are ipso facto members of the Association, together with any other members approved by the Board.

ARTICLE XIV
ASSOCIATION RELATIONSHIPS

Section 1 - Affiliation With Other Professional Organizations

All members shall be encouraged to maintain active membership in local, national and international organizations. The Association may seek affiliation with like intended organizations as determined by the Board of Directors.

ARTICLE XV
LIQUIDATION

Section 1 - Dissolution

In the event of the liquidation and dissolution of the NCE, any properties, funds or monies, securities or other assets remaining in the treasury of, or to the account of, or otherwise belonging to, the NCE shall be disposed of as follows:

1. All liabilities and obligations of the NCE shall be paid and discharged, or adequate provision shall be made therefor.

2. Assets held by the NCE subject to legally valid requirements for their return, transfer or conveyance, upon dissolution and liquidation, shall be returned, transferred or conveyed in accordance with such requirements.

3. All remaining assets held by the NCE shall be transferred or conveyed, without obligation, to another association or foundation selected by the Board of Directors in office at the point dissolution as decided upon.

State of Delaware
Secretary of State
Division of Corporations
Delivered 10:16 AM 03/20/2006
FILED 10:16 AM 03/20/2006
SRV 060263431 - 4128625 FILE

STATE *of* DELAWARE
CERTIFICATE *of* INCORPORATION
The National Congress of Employees Inc.
A NON-STOCK CORPORATION

ARTICLE I

The name of the Corporation is The National Congress of Employees Inc.

ARTICLE II

The name and address information of the Registered Agent and Registered Office of the Corporation in the State of Delaware is:

National Registered Agents, Inc.
160 Greentree Drive, Suite 101
Dover, Delaware 19904
In the county of Kent

ARTICLE III

The purpose for which the corporation is formed is: The mission of the Association is to advocate on behalf of members, individually and collectively at the state and federal level and be a key business resource for small, independent business in America. To render public services as non-partisan, non-profit, organization. To develop acquaintance and fellowship, undertake projects, and act upon matters of common interest and welfare to the members of the association; To instill, foster, encourage, and promote among members of the association the importance of adhering to the highest ethical standards of their respective professions; To establish facilities and provide forum for the interchange of ideas, opinions, technical know-how, networking and experiences among members of the association and other national and international organizations. Further, said corporation is organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

ARTICLE IV

No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article Third hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or (b) by a corporation, contributions to which are deductible under section 170(c)(2) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

ARTICLE V

Upon the dissolution of the corporation, assets shall be distributed for one or more exempt purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a Court of Competent Jurisdiction of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

ARTICLE VI

The corporation shall not have any capital stock, and the conditions of membership shall be as follows: The conditions of the membership are as stated in the bylaws.

ARTICLE VII

The name and mailing address of the incorporator of the Corporation is as follows:

Christopher G. Sabatella
3809 Ocean View Ave.
Brooklyn, New York 11224

ARTICLE VIII

I, The Undersigned, for the purpose of forming a corporation under the laws of the State of Delaware, do make, file and record this Certificate, and do certify that the facts herein stated are true, and I have accordingly hereunto set my hand

this 27th day of February, A.D. 2006.

Christopher G. Sabatella

Christopher G. Sabatella, Incorporator

SERFF Tracking #:	*UNKP-128717823*	***State Tracking #:***		***Company Tracking #:***	*AH990017 NCE*

State:	*Arkansas*	***Filing Company:***	*Wesco Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*Single Case Association Filing - NCE*		
Project Name/Number:	*NCE Single-Case LB Association Filing/AH990017 - NCE*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/08/2012	Replaced 10/26/2012	Form	Limited Benefits Certificate	10/24/2012	WIC-AH-AD-CERT(0312) NCE.pdf (Superceded)

Underwritten by Wesco Insurance Company
59 Maiden Lane
New York City, NY 10038

Policyholder: *National Congress of Employers (NCE)*

Policy Number: *NCE1234567*

We have issued a Policy to the Policyholder named above for the benefit of [members][employees] of the Policyholder. The provisions of the Policy that are important to You are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to You earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy.

Table of Contents
Definitions
Insured Person Period of Coverage
[Insured Dependent Period of Coverage]
Premiums
General Exclusions
Benefits
Claims

Group Limited Benefits Certificate of Coverage

[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS. READ THIS CERTIFICATE CAREFULLY.]
[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS. IT ALSO PROVIDES A LIMITED SICKNESS BENEFIT. IT IS, THEREFORE, IMPORTANT TO READ THIS CERTIFICATE CAREFULLY.]

Signed for Wesco Insurance Company

President

Secretary

GENERAL DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs at an identifiable time and place while the Policy is in force with respect to the Covered Person.

[Active Work and Actively at Work – The eligible employee is performing all of the usual and customary duties of his or her or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the person to travel.]

Certificate Year: For the first year is the period of time that begins on the Covered Person's Effective Date and ends on the day before the next following anniversary date. For subsequent years, it is the period of time that begins on the first and each subsequent anniversary and ends on the day before the next anniversary.

Covered Accident means an Accident those results in a Covered Loss.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an Injury, and for which benefits are payable under this Policy.

Covered Person means You [or Your Eligible Dependent] while covered under the Policy.

[Confined and **Confinement** mean:
a) being admitted to a Hospital for receiving inpatient hospital services; and
b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a charge is made for the last day.]

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices.
2. Acting within the scope of their license.
3. Not one of the following:
   - A person who ordinarily resides in Your household
   - A member of Your immediate family
   - The Policyholder.

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and
2. Your Domestic Partner is at least 18 years of age; and
3. You and Your Domestic Partner are not married or related by blood; and
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and

[5. [You and Your Domestic Partner have filed a Domestic Partner affidavit with Us; and]

6. You and Your Domestic Partner are not legally married to anyone else.]

[Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4. provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for drug addicts or alcoholics; or
3. a place for rest, custodial care, or for the aged.]

Immediate Family Member means a Covered Person's parent, step-parent, spouse, child, step-child, brother or sister.

Injury means bodily injury resulting directly from Accident and independently of all other causes which occurs while the Covered Person is covered under the Policy. Loss resulting from:

1. sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2. medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

We, Us or Our means the insurance company named on the face page.

Written Request means any form provided by Us for the particular request.

You, Your or **Insured Person** means an Eligible Person while he or she is covered under the Policy.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date: Subject to payment of any premium due, if You give Us a Written Request, Your coverage becomes effective on the later of:

1. the Policy Effective Date; or
2. The date You meet all the eligibility and enrollment requirements, subject to payment of premium when due.

[You must be Actively At Work on the date Your insurance becomes effective. (If the date that insurance was to go into effect is not a normally scheduled work day for You, You must have been Actively at Work on the last scheduled work day prior to the date insurance becomes effective under the Policy). If You are not so Actively at Work, Your insurance will be deferred until the date You are Actively at Work.]

Termination: Your coverage terminates on the earlier of:

1. the date the Policy is terminated; or
2. the Premium Due Date on or next following the date You:
   a) cease to be an Eligible Person;
   b) attain the Policy Age Limit, if any, shown in the Schedule of Benefits; or
   c) fail to pay any required premium, subject to the Grace Period provision.

Request For Change In Coverage: If You give Us a Written Request for a change in Your coverage, and if You:

a) are not eligible for the coverage requested, the change will not become effective;
b) are eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[INSURED DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated on Your Schedule.

Eligibility: Eligible Dependents are defined below. In any event, You, the Insured Person, are not an Eligible Dependent.

Eligible Dependents:
1**. Spouse** means Your spouse [or Domestic Partner] unless:
a) You and Your spouse are legally separated or divorced [the domestic partnership is dissolved]; or
b) He or she has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means Your unmarried child, stepchild, legally adopted child, or foster child:
a) who is less than age [19] and primarily dependent on You for support and maintenance; or
b) who is at least age [19] but less than age [24] who:
1) regularly attends an institution of learning; and
2) is primarily dependent on You for support and maintenance.

Effective Date: Subject to payment of the premium due, each Eligible Dependent will become covered under the Policy on the later of:
1. the date You become an Insured Person;
2. the first day of the month on or next following the date We receive Your Written Request for coverage of Dependents; or
3. the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:
1. the date You cease to be an Insured Person; or
2. the date he or she ceases to qualify as an Eligible Dependent.

However, if dependent's coverage would terminate because of Your death, coverage will continue until the premium due date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.

[Surviving Spouse Continuation: If You die while Your Spouse is covered under the Policy, Your Surviving Spouse may continue:
1. his or her coverage; and
2. coverage of Your dependent children who were covered by the Policy on the date of Your death.

We must receive a request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, the Spouse will be considered the Insured Person. However, this will not continue the spouse's or any dependent children's coverage beyond:
1. a date the coverage would normally cease under the Dependent Termination Provision; or
2. the premium due date next following the date the Spouse remarries.]

Request For Change In Coverage: If You give Us a Written Request for a change in the coverage of Your Eligible Dependents, and if he or she:
1. is not eligible for the coverage requested, it will not become effective; or
2. is eligible for the coverage requested, the change will become effective on the first day of the month on or next following the date We receive the request.

[Incapacitated Child: Coverage of a child who, on the date he or she reaches age [19] or [24], is:
1. covered under the Policy;
2. mentally or physically incapable of earning his or her own living; and
3. unmarried and primarily dependent on You for support and maintenance;

will not terminate solely due to age.

However, You must give Us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:
1. the incapacity continues; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.]

PREMIUMS

The first premium for each Covered Person is due on the date You enroll Yourself and any eligible Dependents under the Policy. Each premium after the initial premium is due at the end of the period for which Your preceding premium was paid. [We will send you a bill for the premium due in advance of the due date.] See the Schedule of Benefits for the Frequency of Premium payment.

Individual Grace Period: After the first premium has been paid, You will have a 31 day grace period following the date Your next premium is due. If Your premium has not been received by Us before the 31 day grace period, Your coverage under the Policy will terminate in accordance with the Termination Provision.

GENERAL EXCLUSIONS

The Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
5. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
6. Injury sustained while committing or attempting to commit a felony.

BENEFITS

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If Injury to the Covered Person results, within 365 days of the date of a Covered Accident, in any one of the losses shown below, We will pay the benefit amount shown below for that Covered Loss. The Principal Sum is shown in the attached Schedule of Benefits. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same Covered Accident.

For Loss of :	The Policy Pays:
Life	The Principal Sum
[One Hand and One Foot	The Principal Sum]
[Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum]
[Speech and Hearing	The Principal Sum]
[Either Hand or Foot and Sight of One Eye	The Principal Sum]
[Either Hand or Foot .	One-Half The Principal Sum]
[Sight of One Eye	One-Half The Principal Sum]
[Speech or Hearing	One-Half The Principal Sum]
[Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum]

Loss means with regard to:

1. hands and feet, actual severance through or above wrist or ankle joints;
2. sight, speech or hearing, entire and irrecoverable loss thereof;
3. thumb and index finger, actual severance through or above the metacarpophalangeal joints.

Covered Dependents: We will pay percentage of Your Principal Sum as described in the Schedule of Benefits.]

[IN HOSPITAL INDEMNITY CASH

We will pay the Hospital Confinement Benefit shown in the Schedule of Benefits if a Covered Person is Hospital Confined and all of the following conditions are met.

1. The Hospital stay is the direct result, from no other causes, of Injuries sustained in a Covered Accident.
2. The Hospital stay begins within 7 days of a Covered Accident and lasts for the Time Period for Confinement shown in the Schedule of Benefits. We will pay this benefit retroactive to the first day of the Hospital stay.

Benefit payments will end on the first of the following dates:

1. the date the Hospital stay ends; or
2. the date the Covered Person dies; or
3. the date the Maximum Benefit Period for this benefit ends;
4. the date insurance under the Policy ends.]

[NON-OCCUPATIONAL WEEKLY ACCIDENTAL INCOME BENEFIT

We will pay the Benefit shown in the Schedule of Benefits (less Reductions and Other Income Benefits) if a Covered Person is Totally Disabled as a direct result of, and from no other cause but, a Covered Accident. Benefits will begin when:

1. the applicable Benefit Waiting Period shown in the Schedule of Benefits for this benefit is satisfied; and
2. the Covered Person provides satisfactory proof of Total Disability to Us.

Benefit Payments will end on the first of the following dates:

1. the date the Covered Person dies; or
2. the date the Covered Person is no longer Totally Disabled; or
3. the date the Maximum Benefit Period for this benefit ends; or
4. the date the Covered Person fails to submit satisfactory proof of continuing Total Disability.

Benefits are based on a week of seven days. If Your Benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of Your weekly rate.

Reduction of Benefits Due to Other Sources of Income: Your Disability benefit amount will be reduced as much as is necessary to keep the total of the amount payable plus all of Your income from other sources from being more than 70% of Your gross average weekly earnings from all salaries, wages, commissions, bonuses, and other direct regular income.

Exclusion:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not provide benefits for a Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation, Employer Liability Law, or other similar law.

[This benefit is not available to Covered Dependent Children.]

In addition to the definitions in the GENERAL DEFINITIONS section, the following definition applies to this benefit:

Total Disability or **Totally Disabled** means, due to an Injury from a Covered Accident, a Covered Person:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and
2. if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.]

[EXCESS ACCIDENT MEDICAL EXPENSE BENEFITS

After a Covered Person has satisfied the Deductible and subject to the Coinsurance amount shown in the Schedule of Benefits, We will pay Excess Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. Benefits are payable up to the Benefit Maximum Amount shown in the Schedule of Benefits.

Excess Accident Medical Expense Benefits are only payable:

1. for Usual and Customary Charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses that the Covered Person receives;
3. the first treatment or service occurs within 90 days of the **Covered Injury**; and
4. the medical expenses are incurred within 52 weeks of the **Covered Injury**.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses when Medically Necessary are:

1. Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
3. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. Doctor non-surgical treatment/examination expenses (excluding medicines) including the Doctor's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Doctor.
7. Doctor's surgical expenses.
8. Assistant surgeon expenses when Medically Necessary.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
10. Outpatient laboratory test expenses
11. Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
12. X-ray expenses (including reading charges) but not for dental X-rays
13. Diagnostic Imaging Expenses: including Magnetic Resonance Imaging (MRI) and CAT Scan.
14. Dental Expenses including x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Accident.
15. Ambulance expenses for transportation from the emergency site to the Hospital.
16. Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.

17. Prescription drug expenses (for injuries only) prescribed by a Doctor and administered on an outpatient basis.
10. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
11. Medical services and supplies: expenses for blood and blood transfusions; oxygen and its administration.

Exclusions:

In addition to the GENERAL EXCLUSIONS section in this Certificate, We will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless Medically Necessary for the treatment of the Covered Injury.
2. Any medical expenses related to pregnancy unless Medically Necessary for the treatment of the Covered Injury.
3. Covered Injury for which the Covered Person is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
4. Travel outside of the United States of America.
5. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals.
6. Treatment by an Immediate Family Member.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless Medically Necessary for the treatment of the Covered Injury.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless Medically Necessary for the treatment of the Covered Injury.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [Experimental/Investigational treatments or procedures].
11. [A Medical Repatriation.]
12. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
13. Expenses which the Covered Person is not legally obligated to pay.
14. [Expenses for Custodial Services or services provided by a private duty nurse unless such expenses are incurred as a result of a Covered Injury.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the Covered Injury has caused further impairment in the underlying bodily condition.]
16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a Covered Injury.]
17. [being legally intoxicated while operating a motor vehicle.
    a. A Covered Person will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the Accident occurred.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the Covered Person's legal intoxication.
18. [Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a Physician for the Covered Person. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)].

In addition to the definitions in the GENERAL DEFINITIONS section, the following definitions apply to this benefit:

Coinsurance means the percentage of Usual and Customary Charges for which the Covered Person is responsible for a covered service. The Coinsurance percentage is shown in the Schedule of Benefits.

Deductible means the amount of Covered Medical Expenses that must be paid in full by You each Certificate Year for each Covered Person before any benefits are payable by Us. The Deductible is shown on the Schedule of Benefits.

Experimental / Investigational means treatment, a device or prescription medication which is recommended by a Doctor, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered.

Medically Necessary means the services or supplies provided by a Hospital or Doctor that are required to identify or treat an Injury and which are:

1. consistent with the symptom or diagnosis and treatment of a Covered Person's Injury;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a Covered Person, a Doctor or other provider; and
4. the most appropriate supply or level of service that can be safely provided to the Covered Person.

Usual and Customary Charges means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.]

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give Us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include Your name and the Policy number. Send it to Our administrative notice or give it to Our agent.

Claim Forms: When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to Us in writing within 90 days after:

1. the end of a period of Our liability for periodic payment claims; or
2. the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1. on a monthly basis, after We receive the proof of loss, while the loss and liability continue; or
2. immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of life:

1. according to the beneficiary designation in effect under the Policy at the time of death; or
2. if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
3. to Your estate.

All other benefits due and not assigned will be paid to You, if living. Otherwise, the benefits may, at Our option, be paid:

1. according to the beneficiary designation; or
2. to Your estate.

If a benefit due is payable to:

1. Your estate; or
2. You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to You or the beneficiary by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to You. The written decision will:

1. give the specific reason or reasons for denial;
2. make specific reference to the Policy provision on which the denial is based;
3. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. The claimant may:

1. request a review upon written application within 60 days of the receipt of claim denial;
2. review pertinent documents;
3. submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons on which the decision is based.

Examination and Autopsy: While a claim is pending We have the right, at our expense:

1. to have the person who has a loss examined by a physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1. before 60 days following the date proof of loss is sent to us;
2. after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving Your Written Request to the Policyholder. Your request takes effect on the date You execute it, regardless of whether You are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment We made in good faith before the Policyholder received Your request.

Assignment: We will recognize any assignment You make under the Policy, provided:

1. it is duly executed; and
2. a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Time Limit on Certain Defenses: After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured Person in the enrollment for coverage shall be used to void the Policy or deny a claim.

Fraudulent Misstatement: If a Covered Person makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the coverage at any time.